House of Representatives

General Assembly

File No. 241

January Session, 2003

Substitute House Bill No. 6444

House of Representatives, April 8, 2003

The Committee on Insurance and Real Estate reported through REP. OREFICE of the 37th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT CONCERNING CONTRACTS BETWEEN MANAGED CARE ORGANIZATIONS AND PROVIDERS AND THE RECODING OF HEALTH INSURANCE CLAIMS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective January 1, 2003)* (a) As used in this section, (1) "managed care organization" means a managed care organization, as defined in section 38a-478 of the general statutes, (2) "provider" means a provider, as defined in section 38a-478 of the general statutes, (3) "enrollee" means an enrollee, as defined in section 38a-478 of the general statutes, (4) "commissioner" means the Insurance Commissioner", and (5) "recode" or "recoding" means the changing, by a managed care organization on a claim submitted by a provider, of a code or group of codes for health care services for the purpose of reimbursing the provider at a lower rate. "Recode" or "recoding" includes, but is not limited to, the reduction of an evaluation or management service level, the combining of codes for two or more separate and distinct services or procedures performed on a single

patient during a single office visit, the change of a code to a different classification code, or the bundling of physician services codes in any manner that conflicts with the American Medical Association's Current Procedural Terminology coding policy or instructions.

(b) On and after January 1, 2004, any provider who is aggrieved by a recoding and who has exhausted any internal mechanisms provided by a managed care organization to appeal such recoding may appeal the recoding to the Insurance Commissioner in accordance with this section.

(c) (1) To appeal a recoding, a provider shall, within thirty days from receiving a final written determination from the managed care organization, file a written request for appeal with the commissioner. The appeal shall be made on forms prescribed by the commissioner and shall include the filing fee provided for in subdivision (2) of this subsection and a general release executed by the enrollee for all medical records pertinent to the appeal.

(2) The filing fee shall be twenty-five dollars and shall be deposited into the Insurance Fund established in section 38a-52a of the general statutes.

(3) Upon receipt of the appeal together with the executed release and appropriate fee, the commissioner shall assign the appeal for review to an entity engaged by the commissioner pursuant to subsection (d) of this section.

(4) Upon receipt of the request for appeal from the commissioner, the entity conducting the appeal shall conduct a preliminary review of the appeal and accept the appeal if such entity determines: (A) The provider has or had a contract or other arrangement with the managed care organization; (B) the benefit or service that is the subject of the appeal reasonably appears to be a covered service, benefit or service under the agreement provided by contract to the enrollee; (C) the provider has exhausted any internal appeal mechanisms provided to the provider by the managed care organization; and (D) the provider

has provided all information required to make a preliminary determination including the appeal form, a copy of the final recoding decision and a fully-executed release to obtain any necessary medical records from the managed care organization, enrollee and any other relevant provider.

(5) Upon completion of the preliminary review, the entity conducting the review shall immediately notify the provider in writing as to whether the appeal has been accepted for full review and, if not so accepted, the reasons therefor.

(6) If accepted for full review, the entity shall conduct such review in accordance with the regulations which the Insurance Commissioner shall adopt, after consultation with the Commissioner of Public Health, in accordance with chapter 54 of the general statutes.

(d) To provide for such review the Insurance Commissioner, after consultation with the Commissioner of Public Health, shall engage impartial health entities to provide medical review under the provisions of this section. Such review entities shall be known as an external board of review and shall be composed of representatives from (1) medical peer review organizations, (2) independent utilization review companies, provided any such company is not related to or associated with any managed care organization, and (3) nationally recognized health experts or institutions approved by the commissioner.

(e) The commissioner shall accept the decision of the external board of review and shall notify the managed care organization or its agent and the provider of the decision. If the external board of review finds that the claim should not have been recoded, the managed care organization shall pay the provider the amount of the claim plus interest at the rate of fifteen per cent per annum except that no interest shall be due if the board finds that the recoding resulted from the provider's failure to submit necessary claim information. If the external board of review finds that the recoding was justified, the provider shall pay the managed care organization a penalty in the amount of

fifteen per cent of the amount of the claim. The decision of the commissioner shall be binding and final.

(f) The requirements of subdivision (15) of section 38a-816 of the general statutes shall continue to apply and shall not be affected by the procedures set forth in this section.

This act shall take effect as follows:	
Section 1	*January 1, 2003*

INS *Joint Favorable Subst.*

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either House thereof for any purpose:

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Type	FY 04 $	FY 05 $
Insurance Dept.	IF - Cost	Potential Significant	Potential Significant
Insurance Dept.	IF - Revenue Gain	Potential	Potential

Note: IF=Insurance Fund

Municipal Impact: None

Explanation

The bill could result in a significant cost[1] to the Department of Insurance (DOI) depending on the level of coding appeals that occur. The bill specifies that providers such as doctors and hospitals that are aggrieved by recoding decisions and that have exhausted their internal appeal mechanisms can appeal the decision to DOI. The number of recoding appeals that could occur is unknown but could be significant, possibly in the thousands.

Under the bill, DOI would be required to fund the cost of employing an external review board. Currently, the per-review costs of external appeal entities vary from $60 to $125 for a "preliminary" review to ensure the "package" received by the "applicant" is complete. If accepted for a "full" review, the cost ranges from $350 to $695 (including preliminary review) per review. The range is based on the level of expertise needed as determined by the external review company.

The bill also specifies that each appeal be accompanied by a $25 filing fee. This would result in a revenue gain that is dependent on the

[1] OFA defines "significant" as exceeding $100,000.

number of appeals filed.

OLR Bill Analysis
sHB 6444

AN ACT CONCERNING CONTRACTS BETWEEN MANAGED CARE ORGANIZATIONS AND PROVIDERS AND THE RECODING OF HEALTH INSURANCE CLAIMS

SUMMARY:
Beginning January 1, 2004, this bill establishes an administrative appeal for health care providers who are aggrieved by a claim or reimbursement recoding. As defined under the bill, recoding is changing health care service codes or group of codes by managed care organizations (MCOs) to lower the amount paid to providers. It includes (1) reducing an evaluation or management service level, (2) combining codes for two or more separate and distinct services or procedures performed on a single patient during a single office visit, (3) changing codes to different classification codes, or (4) bundling physician service codes in any manner that conflicts with the American Medical Association's Current Procedural Terminology coding policies or instructions.

The bill requires the insurance commissioner, after consulting with the public health commissioner, to engage impartial health entities to make medical reviews. The entities must be composed of representatives from (1) medical peer review organizations, (2) independent utilization review companies, and (3) nationally recognized health experts or institutions the commissioner approves. Utilization review companies may not be related to or associated with any MCO. The review entity is called the External Board of Review.

The bill also requires the insurance commissioner, after consulting with the public health commissioner, to adopt regulations specifying how the External Board of Review must conduct such reviews.

EFFECTIVE DATE: January 1, 2004

APPEAL PROCEDURE

Filing Requirements

The bill requires aggrieved providers to first exhaust any internal appeal mechanisms offered by the MCO before initiating an appeal to the commissioner. Within 30 days of receiving a final written determination from the MCO, the provider must file a written request for appeal with the commissioner. The appeal must be on forms prescribed by the commissioner, include a $25 filing fee for deposit in the Insurance Fund, and include a general release executed by the enrollee for medical records pertinent to the appeal. The commissioner must assign the appeal to the External Board of Review on receiving the appeal, fee, and release.

Review By Board

The bill requires the board to conduct a preliminary review of the appeal and accept it if the board determines the (1) provider has or had a contract or other arrangement with the MCO; (2) benefit or service that is the subject of the appeal appears to be covered under the enrollee's contract; (3) provider exhausted any internal appeal offered by the MCO; (4) provider has provided all information required to make a preliminary determination including the appeal form, a copy of the final recoding decision, and a fully executed release to obtain medical records from the MCO, enrollee, or any other provider.

Upon completion of its preliminary review, the bill requires the board to immediately notify the provider in writing whether the appeal has been accepted for full review and, if not, its reasons for rejection. If the appeal is accepted for full review, the board must conduct it according to regulations the commissioner must adopt, after consulting with the public health commissioner.

Board Decision

The bill requires the commissioner to accept the board's decision and notify the MCO or its agent, and the provider. If the board finds that the claim should not have been recoded, the MCO must pay the provider the amount of the claim plus 15% interest. No interest is required if the board finds that the recoding resulted from the provider's failure to submit necessary claims information. If the board finds that the recoding was justified, the provider must pay to the MCO a penalty of 15% of the amount of the claim. The bill specifies that the commissioner's decision is binding and final.

The bill specifies that the requirements of timely payment of claims under the Unfair and Deceptive Insurance Practices Act continue to apply.

BACKGROUND

Unfair and Deceptive Insurance Act or Practice

The law requires insurers and other entities responsible for paying health care providers under an insurance policy to pay claims within 45 days after the claimant's insurer receives the proof of loss form or the health care provider's request for payment is filed according to the insurer's practice or procedure. When there is a deficiency in the information needed to process the claim, the insurer must (1) send written notice to the claimant or health care provider of all alleged deficiencies needed to process the claim within 30 days after the insurer receives a claim for payment or reimbursement, and (2) pay the claim within 30 days after the insurer receives the information requested. Insurers and others that fail to pay claims in a timely manner must pay the claim plus 15% interest in addition to other penalties that may be imposed. The failure is also an unfair and deceptive act or practice in the business of insurance. The insurance commissioner, after notice and hearing, may (1) issue a cease and desist order; (2) order the payment of a monetary penalty of up to $1,000 for each act or practice, or up to $10,000 for egregious acts or practices; (3) suspend or revoke a license; or (4) demand restitution.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute
Yea 11 Nay 7